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# Qualitative Evaluation of Clinical Pharmacist Prescribing Input into the Care of People Experiencing Homelessness

Sarah Johnsen, Fiona Cuthill  
and Janice Blenkinsopp



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## Key Findings

This qualitative evaluation has assessed patient and other stakeholder experiences of, and perspectives regarding, the Pharmacy Homeless Outreach Engagement Non medical Independent Rx (PHOENIX) service in Glasgow. The PHOENIX service is staffed by prescribing clinical pharmacists employed by the NHS and a dedicated worker from the Simon Community Scotland street team. It is delivered within a specialist health clinic for homeless people and via outreach in a range of the city's day centres, temporary accommodation settings, and on the street. The evaluation involved interviews with all four staff members involved in delivering the service, 10 representatives of stakeholder agencies who support the same patient population, and 40 individuals with current or recent experience of homelessness.

The key findings were as follows:

- The outreach element of the service acts as a critical bridge to both primary and secondary healthcare for people experiencing homelessness who are reluctant to utilise, or physically unable to access, alternative (mainstream or specialist 'homeless') healthcare provision.
- The informal, flexible and person-centred approach to service delivery is widely viewed as effective in engaging with, and increasing medicine adherence amongst, those patients who are otherwise reticent to use medical (or other) establishments given past negative experiences.
- The proactive immediacy of response (including provision of prescriptions where relevant) is considered a crucial ingredient in the initiation and maintenance of patient engagement, given the capitalisation of 'windows of opportunity' when patients are motivated to address healthcare needs.
- A number of patient interviewees attributed improvements in their health, at least in part, to the service. It also encouraged some to elevate consideration of their health amongst their (many, competing) priorities whilst homeless.
- The service has been welcomed by the providers of temporary accommodation and other (non-health-related) homelessness services (e.g. day centres) given its success in providing, and facilitating access to, healthcare for their clientele.
- The service complements, and alleviates some of the pressure felt by, local homelessness agencies and other healthcare providers. There is nevertheless an apparent need for greater clarity regarding the responsibilities of, and the governance relationships between, healthcare providers supporting this patient group.
- Most patient and many stakeholder interviewees did not fully comprehend the parameters of the pharmacists' specialist expertise and prescription capabilities (commonly confusing them with other healthcare professionals). In their view, the service's distinctiveness, and greatest value, lies in its informal and flexible engagement approach.

# I. Introduction

## Background

The links between homelessness and poor health have been increasingly well documented within and beyond the UK in recent years (Aldridge et al., 2018). Existing evidence indicates that people experiencing homelessness are disproportionately vulnerable to premature death, and experience ill health at greater rates and at an earlier age than is true of the general population (Morrison, 2009; ONS, 2018; Waugh et al., 2018). Higher mortality rates are generally attributed to acute and chronic medical conditions, substance misuse, violence, suicide or unintentional injury (Baggett et al., 2013; O’Connell, 2005; ONS 2018). The prevalence of tuberculosis, HIV, and hepatitis C is also higher amongst people experiencing homelessness (Dennis et al., 1991; Hwang et al., 2005). Evidence also suggests that levels of multi-morbidity are exceptionally high amongst the most ‘severely and multiply disadvantaged’ members of the homeless population who concurrently experience issues such as substance misuse and/or contact with the criminal justice system (Queen et al., 2017).

Existing literature also highlights the difficulties that healthcare and other service providers encounter in meeting the needs of multiply disadvantaged homeless people (Bramley et al., 2015); so too the barriers and stigmatised attitudes often encountered by homeless people when attempting to access or use mainstream healthcare (Campbell et al., 2015; Elwell-Sutton et al., 2017; Lamb and Joels, 2014). Particular concerns have been expressed regarding this population’s limited use of primary care services which contributes to increased use of acute emergency secondary care services whilst in clinical crises (Fazel et al., 2014). It has also been shown that prescribing and adherence to medicines is lower for people experiencing homelessness as compared with housed populations (Fond et al., 2019; Queen et al., 2017), and that people experiencing homelessness rarely receive preventative care, but rather tend to access healthcare services only when sick or injured, or in need of medicine for pain or distress (Elliott et al., 2001).

Against this backdrop, there is an increased recognition of the failure of mainstream services to meet the health-related and other needs of severely and multiply disadvantaged homeless people (Bramley et al., 2015, forthcoming). Notably, a recent systematic review of inclusion health initiatives highlighted the value of a range of factors improving outcomes for vulnerable populations, including people experiencing homelessness, including: coordinated care, partnership working, service design which takes account of the whole person, service user involvement, active engagement, psychologically informed approaches, and provision of outreach in the community and on the streets (Luchenski et al., 2018). Even so, and echoing gaps in evidence regarding ‘what works’ in addressing homelessness more broadly (Mackie et al., 2017), there remains a paucity of evidence with respect to the effectiveness of interventions aiming to improve the physical health of people who are homeless (Hanlon et al., 2018).

Practitioners are increasingly looking to develop novel interventions that might improve the uptake and effectiveness of healthcare for this population. One such innovation, which has been operating in Glasgow for seven years, is delivered by pharmacists with an independent prescribing qualification employed by NHS Pharmacy Services. Since the service’s inception, the mechanisms of delivery have expanded from being solely health clinic based to include outreach into homelessness services and on the street (Lowrie F et al., 2019; Lowrie R et al., 2017a, 2017b). The service also now involves collaboration with a key third sector homelessness support provider, such that the pharmacists are accompanied by a dedicated worker from the Simon Community Scotland street team (henceforth referred to as the ‘street team worker’) during all outreach clinics. The centrality of pharmacist input sets the service apart from other mobile homeless health services, as a recent comprehensive mapping exercise (limited to England) suggests that almost all existing outreach teams are led by nurses with input from General Practitioners (GPs) and/or other health professionals such as podiatrists or counsellors (Crane et al., 2018).

This report documents the findings of an independent qualitative evaluation of this service, which has recently been named the Pharmacy Homeless Outreach Engagement Non medical Independent Rx (PHOENIX) service (henceforth referred to as ‘the service’). It documents patient, staff, and stakeholder experiences and perspectives regarding the strengths and

weaknesses of the service, with a view to informing its future development. It does not assess impacts on clinical outcomes, but does review participants' thoughts regarding the potential design of a planned Randomised Control Trial (RCT) which would aim to rigorously assess the impact of the service across a range of health and other outcome measures.

This qualitative evaluation of the service was conducted by the Institute for Social Policy, Housing and Equalities Research (I-SPHERE) within Heriot-Watt University in collaboration with the School of Health in Social Science at the University of Edinburgh. It was funded by NHS Greater Glasgow and Clyde. This introductory chapter describes the history, aims, approach, and context of the service, before outlining the aims and methods employed in the evaluation.

## Service history, aims, delivery and context

The PHOENIX service was developed in response to a recognition of the issues affecting the health of people experiencing homelessness described above, and evidence that many people sleeping rough in Glasgow were not utilising the city's specialist Homeless Health Service (HHS) (which is often referred to locally as 'Hunter Street'). It was founded on "the aim of increasing access to healthcare, increasing treatment for acute and chronic conditions and increasing the promotion of ongoing engagement with health services" (Lowrie F et al., 2019, p.2).

As noted above, the range of settings in which the service is delivered has evolved and expanded over time. Pharmacists have provided weekly clinics in Glasgow's HHS as part of the GP team for seven years. Outreach sessions have however also been offered by the pharmacists and street team worker since early 2017 in other services supporting homeless people such as day centres, soup kitchens and the Simon Community Scotland advice Hub, as well as temporary accommodation settings (including homeless hostels and bed and breakfast hotels). The service has also included an element of outreach on the city centre streets since late 2017, funded temporarily by Healthcare Improvement Scotland.

The 'pop-up, drop in' outreach clinics at these venues are typically of a half-day duration held at regular times on a weekly basis. Pharmacists and the street team worker routinely see between four and six patients during each clinic (Lowrie R et al., 2017a). No formal appointment is required: patients either drop in on a first come, first served basis, or sign up with staff of the host agency beforehand. In some, staff actively remind residents or service users that the clinic is happening and/or encourage them to meet with the pharmacist on the day. During street outreach, potential patients are invited to participate in a health check and, if they consent, a venue is found nearby in order that this may take place.

Some consultations occur in private interview or assessment rooms (which is the case in the HHS and some of the outreach settings); others at tables stationed within a public area of the host service (e.g. the main communal area of some day centres). The length of individual consultations varies substantially, with some taking more than an hour; others over a much shorter periods of time, depending on the needs and wishes of the patient. The pharmacists and street team worker also engage in informal proactive conversations with users of the services they visit, explaining what the service can offer and/or using the opportunity to build relationships more generally. Clothing, footwear or shopping vouchers are sometimes offered to incentivise engagement.

With regard to an initial assessment, if patients are willing, a full 'health check' will be conducted. This typically takes between 40 and 60 minutes if completed in its entirety, albeit the level of completion varies on a case by case basis. The tool used (see Appendix 1) assesses several aspects of health: cardiac, respiratory, nutrition, addiction, mental health, feet, blood borne viruses, and sexual health. Near patient tests assessing height, weight, blood pressure, blood glucose and pulse are used, and details of family history recorded. A review of medication is also included. Sometimes patients wish to focus on a specific health-related issue and conversation in initial consultations will focus on that without a (full or partial) health check assessment being undertaken.

Patients' primary care and secondary care clinical records can be accessed by the pharmacist during the consultation in full if their registered GP is based at the HHS; or secondary care records only if the patient's registered GP is not the HHS or they are not registered with a GP. These records are accessed via an NHS laptop with remote connection, after

patients provide written consent. Information collected during health checks is used during the consultation to formulate a plan with the patient on priority issues to be addressed. These issues vary and may include actions such as prescribing, onward referral to addictions teams, and/or direct help with wound care (Lowrie F et al., 2019). The street team worker contributes throughout the consultation, addressing housing, welfare benefits, and other related issues. The service aims to consult with patients repeatedly, usually weekly, at the same venue, to enable progress with the health and housing issues identified during the initial health check. Relevant information is forwarded to the patient's GP after the consultation, and referrals to GPs or other healthcare providers are made as appropriate.

The core staff team consists of three part time clinical prescribing pharmacists (0.9 full time equivalent (FTE)) and one part time dedicated street team worker. Two of the pharmacists are permanent NHS Greater Glasgow and Clyde Pharmacy Services employees and one (0.3 FTE) post is temporary, funded by Healthcare Improvement Scotland. The street team worker is a permanent employee of Simon Community Scotland, also temporarily funded by Healthcare Improvement Scotland.

As independent prescribers, the pharmacists can legally prescribe any medication within their competency. In practice, they prescribe any routine primary care initiated medicines other than those used for the treatment of opiate dependency and to treat alcohol withdrawal, because these are initiated and continued by dedicated addictions teams in Glasgow. The pharmacists work alone in conjunction with the GPs when in clinics at the HHS, and are accompanied by the dedicated street team worker when delivering the service in outreach settings (e.g. hostels, day centres and on the street).

The analyses of service records relating to samples of 124 and 52 patients respectively reported by Lowrie R et al. (2017b) and Lowrie F et al. (2019) provide a helpful overview of the type and nature of interventions delivered. Patients in the samples consisted primarily of white middle-aged Scottish men (mean ages recorded by the two studies were 40 and 45 years) who were living in homeless hostels, other temporary/insecure housing or sleeping rough. The most recent of these reports (Lowrie F et al., 2019) indicates that medications were prescribed during consultations by the pharmacists to 62% of all patients; of these cases, new medications were initiated in 69%, repeat/re-issues of lapsed medications in 66%, and changes made to existing medication in 16%. The pharmacists diagnosed a new clinical issue in 69% of patients. Nearly two thirds (62%) of patients had their presenting symptoms managed by the pharmacist alone. A total of 85% of patients subsequently attended either a follow-up with a pharmacist or onward referral.

Through a one year grant from Healthcare Improvement Scotland, the service has recently expanded to support people who are homeless in Edinburgh, but this report focuses on delivery and experiences in Glasgow only. Glasgow is a particularly apposite context in which to explore the implementation and patient experience of such a service, given recent reports highlighting the scale of rough sleeping (Fitzpatrick et al., 2019) and number of deaths of homeless people within the city (Lennon, 2019). Moreover, analysis of Glasgow's HHS patient-level data has revealed very high levels of multi-morbidity amongst the city's homeless population: the average patient age was 42.8 years, but levels of multi-morbidity recorded were comparable to individuals aged 85 or older in the general population (Queen et al., 2017). Views of the new service in Glasgow have not previously been explored with people who are homeless or with other stakeholders.

In terms of wider policy context, the need to 'do things differently' for the most excluded homeless people, and improve the links between housing and health provision in particular, are now widely acknowledged within Scotland and the UK more widely (Bramley et al., forthcoming; Fitzpatrick et al., 2019; HRSAG, 2018; Hetherington and Hamlet, 2015; see also Vaughn et al., 2018). Parallel to this, and echoing developments in inclusion health more generally (Luchenski et al., 2018), strategic government publications in Scotland and England have, in recent years, advised that the pharmacy workforce increase its role in health promotion in an effort to enhance both capacity and capability in reducing health inequality amongst vulnerable groups, including people experiencing homelessness (PHE, 2017; Scottish Government, 2017).

## Evaluation aims, methods and participant profile

The evaluation was guided by three overall aims, these being to:



- 1) assess homeless people's perceptions and (where relevant) personal experiences of dedicated clinical (prescribing) pharmacist input into their clinical care;
- 2) seek staff and stakeholder views on the strengths and weaknesses of the intervention; and
- 3) consult homeless participants on the design of the proposed RCT.

These aims were underpinned by the following specific research questions:

- What do homeless people think of the current dedicated pharmacist intervention (including the screening phases)?
- What might be done to maximise homeless peoples' uptake of a GP based pharmacy service?
- What do staff and other stakeholders consider to be the strengths and weaknesses of the intervention?
- What do homeless people think should be measured in the context of the planned study?
- What would encourage homeless people to participate in the planned study?
- What would encourage homeless people to remain in the planned study until the end (2-3 years)?

The evaluation involved individual face-to-face, semi-structured interviews with a range of people, these being: staff, stakeholders, and individuals with experience of homelessness. With regard to the first of these groups, all four staff members directly involved in service delivery (i.e. pharmacists and street team worker) were interviewed. A further 10 interviews were conducted with representatives of stakeholder agencies who work in partnership with the service and/or with the same client group, including day centre support workers, hostel key workers, community pharmacists, and healthcare professionals, amongst other roles.

In addition, 40 individuals with current or recent experience of homelessness were interviewed. They were purposively sampled to include a majority of patients who had used the service and could comment on it from personal experience (n=32), and a minority of individuals who had not used it (n=8). The latter were recruited to seek their thoughts regarding what, if anything, might be done to encourage their use of the service or healthcare provision more generally. Individuals with experience of homelessness were also purposively sampled to ensure involvement of patients who first accessed the service via different routes: 17 reported that they had first come into contact with the service in a day centre, 12 in their temporary accommodation (hostel or bed and breakfast hotel), two on the street, and one via the HHS.

Seven of the interviewees with experience of homelessness were female, the remaining 33 male. Their ages ranged between 19 and early 80s, with most in their 30s or 40s. With regard to their housing status at the point of interview, 15 of these interviewees were living in a homeless hostel, 11 had recently secured independent settled accommodation (but were still receiving support from homelessness services such as day centres), five were staying in bed and breakfast hotels, four were sleeping rough, two were staying temporarily with friends or relatives (sofa surfing), two were staying in a temporary furnished flat, and one lived in sheltered housing. Their demographic and housing status profiles were thus broadly reflective of the sample of patients described in Lowrie F et al. (2019).

The interviewees with experience of homelessness self-reported a very wide range of (often long term) physical and/or mental health conditions, of varying degrees of severity. These included, amongst many others: chronic obstructive pulmonary disease, diabetes, angina, arthritis, cirrhosis, HIV, osteoporosis, depression, anxiety, psychosis, and schizophrenia. Several described themselves as an alcoholic and many others reported drinking at harmful levels. A substantial number were past or current users of illicit drugs such as heroin, crack cocaine and/or New Psychoactive Substances, amongst others. Some were polysubstance abusers, and/or consumed prescription drugs (e.g. Valium or diazepam) for non-medical purposes.

Patient interviewees' length and level of involvement with the service also varied: ranging from those who had just met with a member of staff for the first time to a few who had been receiving support on a regular basis for more than a year.

Written informed consent was obtained from all participants. Homeless interviewees were given £20 high street shopping vouchers as a gesture of thanks for their participation. All interviews were conducted on the premises of the services in which participants were recruited to the evaluation, with the exception of two patients whom were interviewed in public cafes after being enlisted from the street.

Almost all interviews were audio recorded. Exceptions included the two patient interviews which were conducted in public cafes (see above), and one stakeholder interview which was conducted in an area of the service premises where confidentiality could not be guaranteed. All audio recorded interviews were transcribed verbatim; detailed notes were recorded immediately after the few that were unrecorded.

Anonymised interview transcriptions and notes were analysed thematically, and in the case of people with experience of homelessness via framework analysis also, with the aid of NVivo qualitative data analysis software. All names, where used, are pseudonyms. Descriptions identifying individual staff members or other patients have been edited out of quotations so as to preserve their anonymity. Ethical approval for the study was obtained from both Heriot-Watt University (reference number 344957) and the NHS Research Ethics Committee (reference number 17/NW/0636).

## Report outline

This report consists of five chapters. Chapter 2 documents the perspectives and experiences of the service's patients, together with insights from people with experience of homelessness who had not engaged with the service. Chapter 3 provides an overview of staff and stakeholder views regarding the service's strengths, weaknesses and operational challenges. Chapter 4 reviews participants' reflections regarding the design of the proposed RCT. The report concludes in Chapter 5 with a review of the evaluation's key findings and recommendations.

## 2. Patient and Non-patient Experiences and Perspectives

This chapter documents the experiences and perspectives of patient and non-patient interviewees. It begins by reviewing levels of awareness of and initial engagement with the service, before reflecting on patients' experience of and response to the delivery approach. This is followed by an assessment of the extent to which, and ways in which, the delivery approach mitigates barriers to healthcare commonly encountered by people experiencing homelessness. The following section of the chapter reviews patient and non-patient interviewees' level of understanding regarding the parameters of the pharmacists' clinical roles. The final sections reflect on the influence that the service has had on patient interviewees' understanding of and priority accorded to their health and, finally, their subsequent engagement with healthcare and other support services.

### Awareness of and initial engagement with the service

Most patient interviewees had first engaged with the service after being encouraged to speak to the visiting pharmacist by the staff or other users of homelessness services hosting outreach clinics. A few had agreed to participate in a health check after being encouraged to do so by one of the pharmacists during informal conversations in a day centre or on the street. Levels of awareness of the service were reported to be higher in day centres – where team members are 'seen by' and interact with service users in communal areas – than in accommodation based settings (e.g. hostels and bed and breakfast hotels) and the Simon Community Hub where the pharmacist is based in a consultation room partitioned from a communal advice area.

Reasons given for not using the service reported by non-patient interviewees included: a fear of using support services in general; satisfaction with the support already provided by their own GP and/or other health professionals; or being unaware that the service existed. It is notable that the latter group were open to using the service in the future, with some commenting that they found the idea of a 'holistic' assessment of health particularly attractive (see also below).

*I don't like speaking to people I don't know. I get really anxious and panicky. And then I drink more and get angry and that makes me not very nice to be about. I'm only talking to you now because [name of friend] just did and said you were nice. (Matthew)*

*[My GP] said to me, at any time, just lift the phone, know what I mean, because, obviously, they know my history ... I've got my GP every two weeks, and I've got my psychiatrist once a month, plus, if I need any help, I just lift the phone, because I've got the [name of service] as well for mental health. I've phoned them a couple of times. (Jason)*

*I've never heard of it [the service]. That sounds alright actually. I like the idea of being able to talk about my health overall, not just what's going on with my feet, or just my drug use or whatever. (Samantha)*

A number of patients reported appreciating the breadth of the assessment conducted during the health check, and in particular the emphasis given to prevention and the management of chronic long-term conditions. No patient interviewee gave any indication that they found the health check process excessive or invasive. Some interviewees struggled to recall specific details of the assessment procedure undertaken, which may reflect, at least in part, the degree of discretion exercised by the pharmacists as regards when and the extent to which the health check tool is employed (see above). Alternatively, it is possible that given the extent of long term problem alcohol and drug use, patients' recall of recent events such as a health check may have been impaired.

Some patient interviewees spoke very positively about the use of incentives, expressing appreciation for the provision of material goods such as football strip or other clothing. Others were indifferent regarding whether such incentives increased uptake of the service, but most agreed their provision was a positive and welcome gesture even so.

*I don't think people would just come down for that [football clothing]. I think they come to see [the pharmacist and street team worker] for a lot of different things, but it's a nice thing they do, know what I mean? (Ryan)*

## Experience of the delivery approach

Patient interviewees' experiences of the service were described in overwhelmingly positive terms. These positive perceptions were based, in part, on the high levels of confidence that patients had in the clinical competence of the pharmacists, together with an appreciation of staff members' proactivity (e.g. willingness to make phone calls during consultations to link patients into other services and capacity to prescribe 'then and there' where appropriate). In this vein, many interviewees reported feeling very reassured by the pharmacists' thoroughness of assessment and immediacy of action.

*They're very professional, they're very helpful ... They were listening to me, and they were asking me questions, and they were taking note[s] ... and they had the form, ticking this, ticking that... They were very good, I have to admit. If people had doctors like those two, I think things would be a lot better in surgeries. (Sean)*

*They were good. They were careful. They knew what they were doing. (Pamela)*

*They work with homeless people on a day-to-day basis, and addiction, and stuff like that, so, aye, they know what they're talking about, and they can get you answers quick as well, you know what I mean. (Michael)*

These positive experiences were also attributed to the informal, 'friendly', flexible and person-centred style of delivery employed by team members. Four key factors were identified as contributing to their experiences. The one most commonly emphasised was the attitude of staff, which was described as friendly, compassionate, respectful and non-judgemental.

*I think I just find them a lot more easy to talk to, easy-going ... They treat us better than a lot of, maybe people that aren't used to dealing with homeless people, or criminals, and that. People that have been in prison, and that. They're all right with it. A lot of other people aren't used to it, and, I don't know ... You can just tell they've been doing it a while, know what I mean? They're used to talking to people like us. You get that vibe off them straightaway. (Ryan)*

*They've got a different approach. I'm not demeaning any of the health services' people, doctors or nurses, but you're more at ease with them [pharmacist and street team worker] ... My doctor's a great guy in many ways, and the practice nurses and pharmacists, but it's a different way of approach in here. They make you more at ease ... They spend time listening to you. They're very good listeners, and they put it into practice what they believe, you know, and it works ... It makes me feel good, aye. I feel really good, relaxed, the way they come across... (John)*

*They just talk like us. When you usually talk to other people, pharmacists, and all that, they usually talk a wee bit different sometimes, and they'll not talk to you. They'll not take the time to talk to you, but that's the first time I feel I sat down and spoke to a pharmacist, in here. I just feel relaxed with them. I think it's good sitting with them, talking about your history, you know? ... I just seem to talk to them differently, better ... I know I don't know them, but it's like that, as if you're talking to somebody you know ... I don't know, they just makes you feel more relaxed ... They don't look down on you, or anything... (Connor)*

Another factor frequently highlighted by patient interviewees was the time spent in consultations, which exceeded that experienced in formal healthcare settings (be they mainstream services or the HHS). Patient interviewees reported that the potential for longer consultations made them feel genuinely 'listened to'.

*Those pharmacists listen to me. My doctor doesn't ... I think the pharmacists that come in here have got time for us, do you know what I mean... (Pamela)*

*If you've got any real problems with your mental health ... [name of pharmacist] is there to listen and I think it's better ... It's different in a way because doctors are only there to help with medication really but, you know, if I felt down I'd be able to talk to [name of pharmacist] about how I'm feeling, do you know what I mean? But a doctor wouldn't - doctors aren't really interested I don't think... (David)*

*I think they're better in here, because, the doctor, it's just in and out. In here you've got half-an-hour, whatever. In the doctor's surgery, you're only in five minutes, back out again, so you can sit here and talk about whatever you want! It's not as if somebody's at the door, telling you to get out. Aye it's all right. It's not as if you feel as if you need to hurry up, because there's other people sitting in that waiting room up at Hunter Street. It's murder! (Isla)*

The convenience of the outreach clinics located in homelessness services and accommodation settings were another characteristic very positively received by patients.

*You don't need to go to them, aye, because you're in your own environment ... They're [hostel staff are] like that, 'There's [name of pharmacist], in to see you.' 'I forgot about that!' Then you get up and get out your bed ... They're like, that, 'Right, I'll be down the stair. Just get up and get your breakfast then', and I was like that, 'Aye, I'll be two minutes.' Just ran up, got dressed, and came back down. (Connor)*

*Whenever I go up to Hunter Street it's an absolute nightmare half the time, because they only take - I think it's eight or nine people, and then they'll have them clearly just straightaway. Where here [day centre], it doesn't matter who's in front of you. You go in, you just sit and wait and then walk over, so it's convenient that way ... So for me, it's convenient, it's handy and I don't have to worry about not getting an appointment. (Donald)*

In addition, a number of patient interviewees drew attention to the 'non-medical' physical environment of the outreach settings that the service was delivered in which they felt made the prospect of a consultation less threatening.

*They don't seem like doctors! ... I think it's because you know that you're not in a doctor's surgery, because I spoke to them no bother. I hate going to see the doctor! ... I think it's because you know that you're just up the stair, and it's like in the house. That's what it's like. So, aye, it's good. (Isobel)*

Together, these factors had made patient interviewees feel relaxed, 'at ease', and able to engage in a constructive conversation about the state of their health and healthcare needs. In so doing the service served to overcome a number of the barriers that homeless people are widely reported to face when accessing healthcare (Campbell et al., 2015).

## Mitigation of barriers to healthcare

The vast majority of patient and non-patient interviewees reported having encountered barriers in accessing healthcare in the past, some of which are shared with the general population more broadly given limits to the availability of and time limits to appointments (Donnelly, 2017). For many, these barriers had deterred them from accessing or maintaining engagement with healthcare, in either the short- or long-term. For all, the informal, friendly and flexible outreach approach described above had gone at least some way to mitigating these barriers. These barriers, and means by which the service had mitigated them, were described by patient interviewees as follows:

- Limited availability of appointments with (mainstream NHS or HHS) GPs

*I never see a doctor ... I phone up in the morning, quarter-to, that they time they give you, quarter-to, and it goes on five past nine, and I'm still trying to get through. Then, then I get through, 'No, there's no appointments'. (Kirsty)*

- Anxiety associated with 'going out' and/or being in crowded places (e.g. clinic waiting rooms)

*There's days I don't like going out, so I'd rather just jump down here and have a talk to them for half-an-hour, and get my tablets ... I hate meeting people. (Isobel)*

*I feel comfortable in this building. There's not a lot of Glasgow city centre I feel comfortable in, including the walk up to Hunter Street, because you meet every waif, stray, and bad-un on the way up there, and ... you will bump into the wrong ones in this city. It's awash with them... (Graeme)*

*I can't handle too busy places, so I scarper. (Campbell)*

- Imperative of avoiding other users of specialist homeless healthcare (or other homelessness) services, given perceived risks to personal safety and/or recovery

*I don't like going out. In Hunter Street, I've got too many pals, or enemies. I told them, 'Look, is there any chance you can get my stuff delivered to [name of hostel]?', and they were like that, 'Aye', so, hopefully, I can get the stuff delivered to that hostel while I'm there, and that way I avoid bumping into pals or enemies. If it's pals, they take me away for drink or drugs, and I end up steaming, or else I bump into somebody that I've hurt, or who's hurt me. (Gary)*

*Sometimes, the likes of, if I go to Hunter Street ... it's all drugs that's there ... I could go there one Friday to get my prescription, and the next minute somebody could be asking, 'Oh, are you looking for...?', and if I'm feeling ... I've had the chance to get it lately, and I'd knock it on the head. I'd just walk away from it all, but, as I'm saying, it's trying to keep myself out of the vulnerable position, and that's a good thing if I could get to see the pharmacist here. (Campbell)*

*It's people I bump into that I don't want to see [in the HHS] ... [In the B&B] I know I can just run down and run back up. I know that I'm not going to meet anybody, and my anxiety's not all over the place, or anything. (Isla)*

- Insufficient time in GP appointments for the comprehensive assessment of and response to healthcare needs

*When I go in [to GP] ... the doctor's never... He's not got enough time. They're on a time limit, aren't they? They're like, ten minutes with everybody, they're just banging through everybody. It's not really their fault, just ... they've got that many people coming and going ... so, it's just the system, isn't it? (Malcolm)*

*They [GPs] deal with like one problem at a time, when you've got 15 problems. (Steven)*

- Limits to confidentiality when visiting specialist clinics at designated times

*[My tablets are for] HIV ... I think everybody knows what you're up for [at HHS] on certain days ... and I don't want anybody to see me ... Obviously, people see you coming down here [in B&B], but it's not as if they know exactly what it's for, do you know what I mean? It's different when I go and see, like, the other nurses ... In here it's a bit more confidential, because ... they don't know what you're seeing the nurse [pharmacist] for, so, aye, it's all right. I prefer it, anyway. (Isla)*

- Perception or experience of stigmatised attitudes (from staff or other patients) in mainstream healthcare settings

*I was once sitting in a doctors' surgery waiting to see a doctor with my wife, now ex, and someone else came in and the receptionist apologised to her for there being two drug users in the waiting room. In front of us! I couldn't believe it. She [ex-wife] just went ballistic. (Ewan)*

*When I was staying in a hostel, I noticed that I was treated a bit differently when I was going to visit doctors and all that. It was as if there was ... a bit of stereotyping, a wee bit of stigma there that homeless people have got to face ... So definitely if there's somebody you can go to that's in this particular place like this, it's a lot easier because they understand straight away what you're going through and stuff. So, aye, you don't have to bother be feeling that you're any sort of marginalised citizen, do you know what I mean? (Scott)*

- Lack of motivation regarding and/or priority accorded to healthcare

*Sometimes I just can't be arsed [going to HHS]. It's a hell of a walk. And sometimes I bump into people on the way and don't end up making it anyway [laughs]. There's little risk of that happening when they come here [hostel]. (Peter)*

- Impaired mobility limiting access to (mainstream and/or specialist) healthcare services



*It saves me going away over there [to see my GP], because, sometimes my legs are sore, my knees, and all that. (Liam)*

## Comprehension of pharmacists' professional roles

Very few patient interviewees fully comprehended the parameters of pharmacists' clinical expertise and, by extension, the distinctions between their roles and that of other healthcare professionals. The male pharmacist was very often referred to by patients as a 'doctor' and female pharmacists (and street team worker) as 'nurses' – despite the care taken by team members and staff in the host agency to be clear about professional identities when interacting with patients or prospective patients. Several patient interviewees noted that they were unclear about whether, and if so when, pharmacists were able to prescribe medication.

*I didn't know they were a pharmacist until I read the card, and then I said, wait a minute, that means they're not a doctor, but, they must have still had to be a doctor to be a pharmacist. (Graeme)*

*Some people assume that they'll be able to give you drugs, but they can't. Or only sometimes, I think. I'm not really sure. (Steven)*

That said, whilst emphasising the importance of the pharmacists' clinical competence (see above), the professional identities or affiliations of team members were accorded relatively little significance in patient interviewees' assessments of the value of the service. Put simply, most patient interviewees paid little if any heed to the specificities of the pharmacists' clinical identities or affiliations: what 'mattered' most to patients (over and above confidence in the pharmacists' competence) was the way in which the service was delivered, and in particular the nature of their interactions with staff.

*Interviewer: Would it make a difference if it was like a nurse you saw, or a doctor you saw, or a pharmacist, or ... ?*

*Interviewee: No, I think it's who they are, because those two [pharmacist and street team worker]... were all right, so it didn't make a difference to me if they were a doctor or a nurse, or whatever ... I think, because they were all right ... friendly, and they made me feel comfy anyway. (Isla)*

*It's just, as I said, they can spend more time with you, and they can get things done for you there and then, and get the ball rolling, so it wouldn't really matter if it was a pharmacist, a doctor, or a nurse, as long as they were doing what they were saying they were doing, and that's it. (Michael)*

## Understanding of and priority accorded to health

As noted above, an assessment of impacts on patient health was beyond of the scope of this qualitative evaluation. Patient interviewees did nevertheless provide detailed qualitative accounts of a number of positive health-related outcomes. One, widely reported, was improved understanding of their health-related conditions and the effects of medication – such as enhanced understanding of the impact of illicit drug use on long-term health, and the potential side effects of prescribed medication, to name but a few examples.

*It was [name of pharmacist] that just was very clear and precise, telling me about the dangers and that and how marijuana is one of the biggest depressants. That's something that's stuck in my head; as soon as they said that ... Very helpful, yes ... Just the way they said, you know you're dealing with a professional person and somebody who knows what they're talking about ... When I spoke about what I'm struggling with and stuff, they were quite understanding and ... made it very clear, which, aye, if you take something like that maybe, you think about it. (Scott)*

*They gave me a bit of stern advice. I didn't actually realise that the likes of paracetamol can kill you. I didn't actually realise that after - I think they said - 10 or 11 you can actually overdose from it. I was like, 'Serious?' I would take probably that on a day sometimes. They told me that and I'm like, 'Right, okay. I didn't realise that.' So yes, they were quite knowledgeable on what they were telling me. (Donald)*

This outcome, and the informal and 'understanding' approach of pharmacists and street team worker described above more broadly, had alleviated the anxieties of many patient interviewees regarding their health and/or what should be expected if they were to be referred on to other mainstream (including specialist) healthcare services.

*A lot of reassurance, giving you peace of mind, and wanting to know what are these tablets, what are they for? The side effects, they'll explain it to you. (John)*

*They told me a wee bit, in layman's terms, which the doctor's never, ever sat down and told me ... Aye, because the doctors ... they'll go like that, 'Well, you've got cirrhosis of the liver', and then they leave it like that. They just leave you in limbo, and they don't tell you, 'Well, you need to go and do this', or how advanced it is, or anything like that. They just leave you there, do you know what I mean, with that thought stuck in your head, and you're like that, 'Oh, shit, cirrhosis. Wait a minute, that's dodgy. Am I going to die? Am I not going to die?', all this. So, they [pharmacists] can answer a few of those questions that was annoying me. (Malcolm)*

Consultations with the pharmacists and street team worker, and in particular cognisance of the apparent 'care' and respect they expressed by taking time to converse with patients about matters unrelated to health, served to elevate consideration of health in amongst their other (many and often competing) priorities.

*They've encouraged me to give a toss, basically, about my wellbeing, you know, because I wasn't really. I was getting really reckless and bang at it, as we say in the parlance of street drugs. I had a rotten habit, you know? ... I would have continued on my merry way, and, there is only two ways out when you are a drug user; death is one, and death always follows a drug user. It's an occupational hazard! (Geoff)*

*Interviewee: They got my medication sorted out. I've still to see them again when they come back*

*Interviewer: And do you think those things would have happened if they hadn't been in?*

*Interviewee: Probably not ... It would just have been put on the back burner. (Michael)*

## **Influence on health and engagement with other services**

A number of patient interviewees attributed improvements in their health, at least in part, to the input of the service. For some this was described as having involved immediate intervention such as dressing wounds or issuing a new or modified prescription for medication which had had a positive impact on their health at the time.

*They contacted ... Hunter Street and they found out what medication I was on. They were able to write a prescription for me ... I went to [name of pharmacy] to get my prescription so it was better, saving a journey, you know, going to the doctors... (David)*

*A lot of people, they've got abscesses, and stuff, with jaggings, or they're going to lose their legs, and stuff like that. They can get them access to bandages, and all that, so it's a good thing, aye. A lot of the guys out there wouldn't go and do that, but if they're going round different hostels, and all that, then they'll get the stuff that they need, aye. (Michael)*

For other patient interviewees, encouragement to access and/or onward referral to other healthcare services by the staff team had catalysed engagement with other primary or secondary healthcare provision which had benefited their health.



*Interviewee: They talked me into going on Methadone*

*Interviewer: Would you have gone on to Methadone if you hadn't spoken to [name of pharmacist], do you think?*

*Interviewee: No ... And I would have continued losing weight and buying street junk, any, whatever poison it is these swine are putting in it, and, with the hectic lifestyle, you don't eat enough as it is. I would have continued to deteriorate health-wise ... My health has taken a few steps better. (Geoff)*

*[The pharmacist is] going to get in touch with my surgery, and because my Prozac, they're [GP surgery is] not really helping me ... What [the pharmacist] suggested was ... there's a medicine out, it's a two-in-one. It can help my blood pressure, and it can also help relax my muscles, or whatever ... They went like that to me, 'I'll try and get in touch with them and try and get this organised for you, so you can go to the chemist'... (Sean)*

*I was sexually abused as a kid and ... used drugs to deal with, to hide from it for years. When I stopped using I could no longer cope with everything, 'cause of what was going on in my head ... [Name of pharmacist] referred me to a counsellor, who I am seeing now. (Angus)*

Importantly, some patient interviewees reported that the service had acted as a conduit to accessing other services for homeless people, such as temporary accommodation, given the role of the street team worker. In such instances, the service had acted as a critical bridge facilitating access to support provision beyond the health sector.

*[Name of pharmacist] and [name of street team worker] have got me back in touch with the housing department ... See them agencies, I wasn't engaging with any of them ... It was too stressful for me. I was running away in fright of these places, and I don't know why, because I can speak to people, really, but, I seemed to get the impression they were all out to do me harm. Paranoid... I definitely wasn't well, really, and [name of pharmacist] kind of snapped me out of it. (Graeme)*

On a related note, patient interviewees highlighted two main benefits from the service's partnership with Simon Community Scotland. Some patients already knew and trusted the street team worker given the street team's work in other homelessness services and on the street in Glasgow, hence reported that they were willing to engage with a pharmacist after being personally introduced by the street team worker. A number of other patients did not have an existing relationship with the street team worker, nor in some cases necessarily fully appreciated the distinction between that worker's professional affiliation and that of the paired pharmacist, but the street team worker's expertise and immediate action to redress patients' problems with housing and welfare benefits were greatly appreciated nevertheless. Further to this, witnessing immediate action in relation to such practical matters served to further enhance a number of patients' inclination to engage with the health related aspects of the service in subsequent clinics.

Further to this, and in light of the barriers to accessing healthcare often faced by people experiencing homelessness (see Chapter 2), a number of things might be noted as regards what could be done to maximise the uptake of a GP-based pharmacy service (see Chapter 1). The first is that many potential patients would require substantial encouragement to attend by a trusted professional (be that a pharmacist, the street team worker, or a support worker based in an agency hosting an outreach clinic). In some instances, they may need to be personally accompanied by that trusted professional to attend a GP-based pharmacy service clinic. Provision should also be made for transport (e.g. a taxi) where appropriate, especially if a patient has limited mobility and/or the risk of them being diverted en route would otherwise be high (see above). Furthermore, action should be taken to reduce the 'waiting room effect', that is, to minimise the risk of patients feeling stigmatised or condescended in mainstream GP clinics or encountering people whom they would rather avoid in specialist 'homeless' GP clinics. That said, the evaluation findings indicate that there will be some people experiencing homelessness for whom such endeavours would still be unlikely to fully overcome their reticence to access GP clinics in formal healthcare settings. For these individuals, outreach is likely to remain their preferred (and possibly only) point of contact with healthcare, in the short-term at least.

## Conclusion

Patient interviewees' experiences of the service, and its outreach component in particular, were reported in overwhelmingly positive terms. The holistic nature of assessments and additional time available for consultations were welcomed, as was the informal, friendly, flexible and person-centred style of delivery adopted by the pharmacists and street team worker. These attributes, together with the convenience and 'non-medical' location of outreach clinics, had been effective in helping many patient interviewees overcome barriers to healthcare previously encountered (and widely reported in literature).

Qualitative outcomes reported by patient interviewees included improvements in understanding of their health-related conditions and prescription medication effects, alleviation of anxieties regarding health, and elevation of consideration given to healthcare needs in amongst their (many and often competing) priorities. Some patient interviewees attributed improvements in health (at least in part) to the service and/or reported that their engagement had facilitated access to other services such as accommodation.

Patient interviewees were very confident in the clinical competence of the pharmacists, but it is notable that most did not fully comprehend the parameters of the pharmacists' specialist expertise and prescription capabilities – commonly confusing them with other healthcare professionals along gender-based lines (that is, assuming the females were 'nurses' and the male a 'doctor', despite the care taken by staff to identify themselves accurately). In the eyes of patient interviewees, the service's distinctiveness, and greatest value, was considered to lie in its informal and flexible engagement approach.

### 3. Stakeholder and Staff Perspectives

Drawing upon the interviews with staff members and other key stakeholders, this chapter reflects on the service's key contributions and strengths, before then providing an overview of what interviewees considered to be its main operational challenges, limits and weaknesses.

#### Key contributions and strengths

There was a strong consensus amongst stakeholder interviewees that the service is highly effective at 'case finding' and engaging with people experiencing homelessness who would otherwise 'fall through the gaps' of healthcare services. Stakeholder interviewees recalled multiple examples of cases wherein the pharmacists and street team worker had successfully engaged with patients who had been seriously neglecting their health and had not accessed healthcare (other than A&E in crises) for prolonged periods of time (sometimes many years). The service was therefore considered to address a key gap in healthcare provision for its target group.

*A lot of this client group would have access to Hunter Street ... but for whatever reason quite often are not willing to engage with them ... and if a lot of them are not registered with a GP or have other health problems ... or generally they are just so chaotic that they're not going to be going to get their prescriptions regularly, or they just don't care about their health and so they're just not making that effort to be getting their prescriptions... Then if [the service] team wasn't there, then these people would be just falling through the cracks. They wouldn't be engaging with anyone at all. (Stakeholder 6)*

*There's people that are going in, you can see them sitting with [name of pharmacist], who, probably, otherwise may not be. I can't see any negatives to it. Genuinely, I can't see any negatives to having a service like that here, based in the places that people go, where you are actually dealing with the most chaotic and vulnerable people at times, and who may not go to Hunter Street ... Hunter Street's a fabulous service, invaluable service, but that [the service's outreach] just complements it... (Stakeholder 1)*

The partnership with Simon Community Scotland and links with other third sector homelessness service providers facilitated by the street team worker were deemed by staff and stakeholder interviewees to be key strengths of the service. These were said to allow for positive exploitation of the relationship that the street team worker already had with many members of the homeless population, thereby facilitating introductions to and fostering (potential) patients' trust in the pharmacists. The street team worker's specialist expertise and connections within homelessness and allied social care services was also deemed invaluable in allowing for the positive exploitation of windows of opportunity initiated by the service, thereby increasing potential for patients' needs beyond health to be identified and addressed.

*That's an excellent way of working hand-in-hand so it's not just the NHS commission but the other stuff can be picked up ... and if an appointment has to be made or returning somebody to that appointment ... which can ... give more power to the actual engagement ... That helps again break down barriers ... for the benefit of the outreach clinic. (Stakeholder 8)*

The staff team's direct links to specialists in podiatry, cardiology, dermatology and respiratory health were similarly highlighted as service strengths, given their facilitation of patient access to secondary healthcare.

Echoing patient perspectives (see Chapter 2), stakeholder interviewees highlighted the benefits of the service's outreach element. This was deemed very effective in helping to overcome patients' reticence to use healthcare services, issues relating to restricted mobility, and/or the so-called 'cannot be bothered' barrier. Some staff and stakeholder interviewees also highlighted the value of delivering the service in environments where people experiencing homelessness may potentially feel more relaxed than they do in medical settings.

*There's a lot of people that would go up to the Hunter Street clinic and absolutely no issues at all, but we do regularly see guys who – 'Oh, I don't want to go to Hunter Street because I want to avoid such-and-such'. It takes a bit of stress out of it. They can come down here, it's more anonymous ... So it's handy, it really is handy that way, especially for guys that have any issues, anxieties about going out and being in public ... [And] again, we tend to find a lot of that can come down to mobility with some of the guys. Some of the guys are paying for taxis out of their own pocket because ... it's too far for them to go to Hunter Street in a wheelchair and stuff like that or with a Zimmer or any sort of walking aid. These guys can actually just come along here to see [name of pharmacist] ... They get their needs met here, yes ... I think it brings a vital service to the folk that can't get to the services. (Stakeholder 3)*

*They are service user friendly, they can engage in our centre in the setting that's normal and relaxed here. There's a dining area, café area where service users will meet and use the centre... (Stakeholder 8)*

The immediacy of response was also regarded as a crucial factor contributing to the service's success in engaging patients. This was said to foster the capitalisation of (in some cases infrequent and brief) 'windows of opportunity' wherein patients are engaged and motivated to address healthcare needs.

*See when you get somebody who's sat there with COPD, can't walk, and has to go to Hunter Street, or somebody who's got leg wounds which need to be treated there and then, but isn't going to Hunter Street, then [name of pharmacist] can do that. That's such a difference, because once they're out this building, we can lose them. The world that they exist in, that sort of chaotic and frenetic world that they exist in, drags them anywhere. (Stakeholder 1)*

*If [name of pharmacist] is visiting somebody in the likes of [name of hostel], they'll send me a message, or a referral through, saying, 'Could you pop out and visit this person?', or even phone me and let me speak with the person there and then. With homelessness, when people have got quite chaotic lives, the there and then is quite a big issue, so, it's quite a big pro... (Stakeholder 9)*

Together, these characteristics were said to mitigate effectively against the potential 'loss' or 'leakage' of patients who may have good intentions re accessing the HHS or other services but nevertheless tend to get 'diverted' from doing so by other people and/or competing priorities.

*Signposting works for some people but not all, and people who it works least for are the people who are in the most chaos and for whom priority isn't always health. If it's not immediately accessible, that is to say where the person is at the time, and when the iron is hot at the time, so to speak ... people don't always make it to the place that's been signposted. But if it's on their doorstep and it's not going to cost any bother, apart from waiting for five minutes, perhaps, then why not and that makes the difference. (Stakeholder 8)*

*We can't let the moment pass where there's an opportunity to do something because I know for a fact the patients know and the literature tells us that they'll just disappear and not come back, or reappear in hospital. (Staff 3)*

In addition, the 'stickiness' of the service was highlighted as a strength, in that the pharmacists continue to follow up cases and encourage patients to re-engage even after periods of disengagement. In this vein, a number of stakeholder interviewees commented on the staff team's commitment and tenaciousness in following up and advocating on behalf of patients.

*I think they're quite a sticky service and we like that ... I think that when you look at some work around vulnerable people with complex issues or whatever, then they often do need a bit of a sticky service. They frequently didn't turn up or didn't do what was asked of them and you still stick with them. I can see evidence of that in terms of that they [the pharmacists] persevere with that. (Stakeholder 5)*

As was true of patient interviewees (see Chapter 2), the informality and person-centeredness of delivery, and respectful demeanour of staff, were identified as key strengths by stakeholder interviewees. These characteristics were considered to have had a very positive influence on levels of patient engagement.

*The feedback that I get from the clients ... I don't know if informal's the word, but ... I think they like it because it isn't as formal. People aren't turning up in a uniform. They're more relaxed; they give you more time. It's not, 'Right, here's your 15-minute appointment. Right, I need to see the next person now', so, I think that's quite a unique thing within the health service ... and the clients seem to respond to that well. (Stakeholder 9)*

*[The pharmacists and street worker have a] very kind, very nice manner with people ... the patients find them easy to work with ... They're absolutely straight with them, on the level with them. I think that's great. They treat them well, with respect. (Stakeholder 7)*

*The practitioners from the outreach service will engage freely and informally with people in a non-threatening way, in a way that gets alongside people as opposed to opposing them and I think it makes it easily accessible that way ... I think they're very personable. They fit in really well. I think they're well liked ... It's not somebody with a white coat on, 'next please' conveyor belt style, no, they're sensitive to the client. (Stakeholder 8)*

The 'holistic' assessment of patients' health and consideration of prevention – enabled by the capacity to conduct broad-ranging health checks and hold longer-than-usual consultations – was also highlighted as valuable by a number of stakeholder interviewees.

*From my point of view, it's a big advantage having somebody who's looking at the overall picture, rather than just their one subject or topic. (Stakeholder 9)*

The pharmacists' proactivity and level of clinical competence was also commented on very positively – in terms of their diagnostic and prescribing expertise, but also their skills in interacting with the patient group. One healthcare professional described the pharmacy team's expertise in the management of long-term conditions in particular as “immensely beneficial”, which is notable given concerns regarding the increased burden of multimorbidity, long term conditions and under-prescribing amongst the homeless population reported in international literature (see for example Asgary et al., 2016; Bernstein et al., 2015; Fond et al., 2019; Queen et al., 2017).

*They obviously have a very good knowledge of all medications and I think for all the physical illnesses and things and we know it's an ageing population that have lots of polypharmacy ... understanding all the interactions and things for that I think is really positive ... They have very high-level skills to do with the medications and illnesses ... which I think are really helpful. (Stakeholder 10)*

*Most patients that we come into contact with have had gaps or difficulties in getting medicines in its simplest form. A lot of them have got quite complex prescribing, so again having somebody who's got the ability and the skill set to unpick some of that and keep patients safe I think is really, really important. (Stakeholder 5)*

On a related point, a number of stakeholder interviewees reported witnessing increased levels of adherence with prescription medication amongst patients which they attributed to the service's input.

*The tangible outcome would clearly be, would be compliance. A group of patients who, had it not been for [name of pharmacist's] team, wouldn't be getting the medicines ... for a wide variety of conditions, including blood pressure problems and so on. So if it wasn't for the team issuing those prescriptions and seeing these patients regularly and doing the blood pressure checks and referring these people on, I don't think anyone else would be able or willing to do it. So, the most kind of noticeable and tangible difference that we're not seeing is simply that. Patients that weren't taking their medicines before, or weren't engaging with services are doing so because of them. (Stakeholder 6)*

Stakeholder interviewees involved in the provision of non-health-related services which hosted outreach clinics reported valuing and feeling very reassured by the availability of medical expertise on-site. For them, access to this expertise alleviated anxieties regarding the limits of their own health-related knowledge and strengthened their ability to advocate on behalf of their service users.

*Having some health professional like [name of pharmacist] knowing what kind of treatment they should be getting ... so you're going in with added expertise as an advocate, rather than just me as an advocate. I've no medical knowledge, or I don't have an understanding, so, stuff like that is fabulous ... It's such a benefit for us in here, as staff, being able to direct somebody, '[Name of pharmacist's] here on a [name of day]. Come and see them.' It's great. (Stakeholder 1)*

In a similar vein, the service was said to complement and relieve some of the pressure felt by other NHS provisions, most notably by taking on some of the responsibilities associated with the treatment of long-term conditions, and filling a number of recognised gaps in healthcare provision for the patient group.

*I think they've been really helpful particularly around patients with long-term conditions, because we sometimes clinically struggle to do some of that because of our limited resource. So they have really helped facilitate some of that ... We've tried to share the burden of some complex patients that we worry about. (Stakeholder 5)*

*Long-term condition management ... is a big thing that the pharmacists have helped us with ... and we can refer patients in for a full medicine reconciliation. We can refer them for diagnosis, spirometry, asthma, all the kind of - so they do that but they can do that as part of it when they're out in the community. They can start a prescription as well which might help a person to engage. (Stakeholder 7)*

## Operational challenges, limits and weaknesses

A number of stakeholder interviewees highlighted a lack of clarity regarding the governance relationships between the service and other healthcare providers supporting the target group. It remained unclear what processes were (or should) be in place regards follow-up for further diagnosis or treatment if an issue had been picked up in an outreach setting but the patient was registered but not actively engaging with the HHS, another GP practice, or addiction services at the time. Further to this, given the imperative of maintaining patient safety and safeguarding standards of care for people experiencing homelessness (Pathway, 2018; Wise, 2018), concerns were expressed in relation to a lack of clarity regarding where responsibility would (or should) lie if something were to go wrong (e.g. if a patient were to suffer a serious reaction to prescribed medication).

Although the service was reported to have positive working relationships with many (mostly but by no means only low threshold) services locally, the different philosophical and delivery approaches of the service and local addiction services was identified as a cause of tension. The service might be described as operating in an opportunistic fashion, taking swift action to capitalise on windows of opportunity at the first point of contact wherever possible; whereas addiction services typically operate in a more programmatic fashion over the longer-term. This clash of philosophy and delivery approach was most evident in relation to the subject of opiate replacement therapy.

Stakeholder and staff interviewees noted that there were limits to the confidentiality afforded by some of the venues in which outreach clinics were held, given that private consultation rooms were not consistently available. That said, this was not seen as especially problematic by most interviewees, given that space for private consultation could normally be found if/when necessary. A number of staff and stakeholder interviewees also noted that the benefits of pharmacists being stationed in communal areas did in some ways outweigh the disadvantages, given the team's increased visibility and the potential generated for initiating informal conversation.

*I'm sure it would be nicer for [name of pharmacist] maybe to have a bit more privacy in a place like this. These [rooms] aren't ideal, know what I mean? We don't even have the ideal premises for us to do the kind of stuff we would like to do. (Stakeholder 1)*



*Even if people are seeing somebody being engaged with at the table or just around the corner, they'll be inquisitive and they'll see that... Maybe that could be for me as well? Because it's right on their doorstep ... it breaks the ice without even a word being spoken, and they might just then enquire, 'What's that about?' and then the staff can say, 'Well, actually...'. The practitioners themselves will be round the table freely and using their people skills and using general conversation that can easily lead to something specifically health related. (Stakeholder 8)*

A number of stakeholder interviewees who worked outwith the health sector acknowledged, in a similar vein to many of their service users (see Chapter 2), that they did not themselves fully understand the clinical distinctions between the roles of pharmacists and other healthcare professionals, nor the parameters of the pharmacists' prescribing capabilities. A few stakeholders noted that awareness raising on this issue would be beneficial, given potential risks associated with any confusion regarding professional identities and/or need to manage patient (and possibly also stakeholder) expectations regarding what the service can do and achieve.

*I'm not really entirely sure, the difference [between a pharmacist and a doctor], because obviously the GP can write prescriptions, as [name of pharmacist] can as well. I'm not sure to be honest. (Stakeholder 3)*

*As a lay person, if that's the word, I think of pharmacy, I think chemist ... And I think as a kid going to get that wee medicated lollipop and things like that and whatever. I've got a sore throat and I'll go to the chemist ... Maybe there's an awareness issue there that, defining the service to the benefit of people who can understand it better ... there's much that a doctor's GP service does that is being also delivered by this pharmacist's outreach clinic. (Stakeholder 8)*

*I think what they [patients] get to know is, it's a health service. That's what they know, 'I can go and speak to them, and they're actually able to give me a prescription, or treat a wound, or get me an appointment. They will speak to my GP. They will get me sorted' ... Some people say, 'I'm here to see the doctor.' ... Do they know what a pharmacist is? Probably, but did they know a pharmacist did that? No, and, I guess, to the same degree that I didn't always realise that a pharmacist could be so proactive... (Stakeholder 1)*

That issue notwithstanding, it was widely agreed that demand for the service outweighed supply, and that there was a case for expanding the length and/or number of outreach clinics delivered so that more people experiencing homelessness might benefit from it.

*Sometimes it would be good if they had a wee bit more time, to put that towards some of the guys, because sometimes, 'Oh, I wanted to see [the pharmacist], and just happened to be that the guy's [service user has] been away. Or maybe they've had things to do during that morning that they're here, and by the time you get back they're away. So, yes, maybe a full-day surgery might be a good idea. (Stakeholder 3)*

## Conclusion

Stakeholder and staff interviewees considered the service highly effective at case finding and engaging with people experiencing homelessness who would otherwise 'fall through the gaps' of existing healthcare provision. The proactive person-centred outreach approach, and strong links with third sector partners facilitated by the street team worker, were deemed pivotal in fostering patient trust and engagement. The immediacy and informality of response, and respectful demeanour of staff, were also viewed as critical ingredients mitigating many of the barriers to healthcare commonly faced by people experiencing homelessness.

The service's holistic approach to health assessment, and consideration given to prevention especially, was widely welcomed by stakeholders. The clinical competence of the pharmacists, and their expertise in long-term condition management in particular, was viewed as another key strength. Some stakeholder interviewees attributed an observed increase in prescription adherence amongst the patient population to the service.

The service was considered by stakeholder interviewees to complement, and to at least some extent alleviate the pressure felt by, local homelessness services and other healthcare providers. There is, nevertheless, a notable lack of clarity regarding the responsibilities of, and governance relationships between, healthcare providers supporting this client group.



## 4. Perspectives Regarding the Proposed Randomised Control Trial

As noted in Chapter 1, opportunity was taken during all interviews to seek participants' thoughts regarding the design of the proposed RCT which would aim to quantitatively assess the impacts of the service's approach. This chapter provides a concise overview of interviewees' views regarding: firstly, potential outcome measures; and secondly, strategies to maximise participant recruitment and retention.

### Outcome measures

Key outcome areas that stakeholder, staff, patient and non-patient interviewees thought the RCT might potentially measure included:

- Number of times engaged with the service
- Self-assessed general overall health
- Blood pressure and weight
- Physical health diagnoses
- Mental health diagnoses
- Drug use (type, frequency, amount, severity of addiction, means of administration)
- Alcohol use (type, frequency, amount, severity of addiction)
- Prescription medication and compliance
- Referrals to and uptake of other health services (HHS, other specialist services, mainstream services, in-patient, out-patient etc.)
- Independent (non-referred) use of other health services
- Referrals to and uptake of non-health services (e.g. temporary accommodation)
- Number of A&E attendances
- Number of hospitalisations (plus reason and length of stay)
- Housing status
- Cost, cost savings, cost-effectiveness and/or cost-benefits

### Recruitment and retention

Stakeholders and individuals with experience of homelessness advised that the best places to recruit potential participants were likely to include the settings where the service already delivers outreach, and similar services within Glasgow, that is: the HHS, day centres/drop-ins, soup kitchens, hostels, night shelter, and bed and breakfast hotels. They did not rule out the potential for recruiting people directly from the street, but emphasised that this would probably be much more difficult and may raise additional challenges as regards minimising attrition (see also below).

There was a strong consensus that the use of incentives was not only desirable on practical and ethical grounds, but in all likelihood necessary if the study is to recruit the numbers required for both intervention and control groups and retain sufficient levels of participation in each for its proposed two-to-three year duration. All emphasised that incentives should take the form of vouchers of some kind rather than direct cash gifts, and that they should be provided after every interview and/or medical assessment.

Interviewees recommended that the study be widely advertised via posters, electronic notice boards and similar media within the range of settings described above. In addition, homeless interviewees in particular emphasised the value of 'personal' invitations to participate in the study, which they recommended come from members of the service team and/or staff members employed by recruiting agencies.

A few interviewees also suggested that enlisting the help of one or more study 'champions' with experience of homelessness to encourage the (other) users of homelessness services to participate in and maintain engagement with the study may be beneficial. These individuals could potentially (but would not necessarily have to) hold a formalised role as a peer researcher and contribute to other phases of the research (e.g. design, data collection, analysis and/or reporting). They noted that such a contribution should be recognised and recompensed formally, be that via financial or in-kind payment.

Some interviewees with experience of homelessness also advised that consideration be given to exploiting the opportunities offered by information and communication technology, and social media in particular, to maintain levels of interest in and engagement with the study for its duration, insofar as data protection legislation allows. They did for example highlight the potential for using text messaging, WhatsApp and/or Facebook to maintain contact with highly mobile members of the target population. They also emphasised the need for the research team to be very flexible, and if necessary 'opportunistic', in arranging repeat contacts or assessments with study participants for the duration of the study.

## 5. Conclusion

This report has documented the findings of an independent qualitative evaluation of clinical pharmacist prescribing input into the care of people experiencing homelessness delivered via the PHOENIx service in Glasgow. The key findings and recommendations emerging from the evaluation are summarised below.

### Findings

Patient interviewees' experiences of the service were described in overwhelmingly positive terms, and stakeholder interviewees considered it to be highly effective at case finding and engaging with homeless people who would otherwise 'fall through the gaps' of existing healthcare provision. Significantly, the outreach element was regarded as providing a critical bridge to both primary and secondary healthcare for people experiencing homelessness who are reluctant to utilise or physically unable to access alternative (mainstream or specialist 'homeless') healthcare provision. The service's integration of a third sector street team worker was considered to add significant value by fostering patient trust and facilitating onward referral for issues not directly health-related.

The informal, flexible and person-centred approach to service delivery was reported to be effective in engaging with those patients who are otherwise reluctant to use medical (or other) establishments. The proactive immediacy of response (including the provision of prescriptions where relevant) was also considered a crucial ingredient in the initiation and maintenance of patient engagement, given the associated capitalisation of 'windows of opportunity' when patients are motivated to address healthcare needs. Together, these characteristics had served to assist patient interviewees to overcome many of the barriers to healthcare that commonly affect people experiencing homelessness.

Whilst a different research design would be required to definitively assess health impacts, a number of patient interviewees qualitatively attributed improvements in their health, at least in part, to the service. The service had also encouraged some patient interviewees to elevate consideration of their health amongst their (many and often competing) priorities whilst experiencing homelessness. Furthermore, some stakeholder interviewees attributed an observed increase in prescription adherence amongst the patient population to the service. The service's holistic approach to health was widely welcomed by patient and stakeholder interviewees, given the greater-than-usual attention granted to prevention and chronic condition management.

The service has been welcomed by the providers of temporary accommodation and other (non-health-related) homelessness services (e.g. day centres) given its success in providing, and facilitating access to, healthcare for their clientele. More broadly, the service was reported to complement, and alleviate some of the pressure felt by local homelessness agencies and other healthcare providers. That said, there is an apparent need for greater clarity regarding the responsibilities of, and governance relationships between, healthcare providers supporting this patient group in a context where the need to safeguard patient safety and care standards is of paramount importance.

Levels of confidence in the clinical competence of the pharmacy team were high, but most patient and many stakeholder interviewees acknowledged that they did not fully comprehend the parameters of the pharmacists' specialist expertise and prescription capabilities. In fact, many confused the pharmacists with or mistook them for other healthcare professionals along gender-based lines (i.e. assuming females were nurses and males doctors), despite the care taken by staff members to be clear about their professional identities. In the eyes of such interviewees, the service's distinctiveness, and greatest value, lies not so much in the clinicians' professional identities or roles per se, but in the informal and flexible engagement approach employed. What 'worked' for them was the service's relational approach, 'stickiness', and actions taken to do everything possible in the 'here and now'.

## Recommendations

Recommendations emerging from the evaluation which might inform the service's development going forward include:

- Care should be taken to maintain the informal relational and 'sticky' outreach approach, capacity for immediate action (including provision of prescriptions where relevant), and focus on holistic needs assessment (including consideration of prevention and long term conditions management in particular), given their positive influence on patient engagement and experience.
- Resources permitting, consideration might be given to increasing the provision of outreach clinics. An expanded staff team might incorporate other health professionals together with third sector housing/social care partners, given the recognised value of multi-disciplinary teams in inclusion health initiatives (Luchenski et al., 2018; Pathway, 2018).
- The pharmacists should always work in conjunction with third sector partners who have strong relationships with the target group and relevant support services, and professional expertise enabling them to address patient needs that are not directly related to health.
- Supervisory and team support, together with upper limits to the proportion of time staff members commit to the service, are necessary given the intense emotional and other demands of frontline delivery.
- Clinical governance relationships between the service and other providers of healthcare for patients should be clarified and strengthened. Consideration might be given to greater use of inter-agency meetings, and potentially also exploitation of opportunities afforded by communication technology during consultations, to further enhance case coordination.
- Further research employing a control group is needed to rigorously assess the impact of the service on patients' health and other outcomes. This should include a wide range of outcome measures and adopt the strategies to maximise participant recruitment and retention recommended by interviewees (see Chapter 4).

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# Appendix: Health check tool

## Pharmacist Health MOT Homeless health – Version 22<sup>nd</sup> Jan 2019

Consultation 1 Date:	Location:
Completed by:	
How was patient brought to your attention?	
Explain: full health check takes at least half hour, voucher available, we link with your GP/worker; we can do more for you if you come back a few times.	

### 1. Consent

Do you consent to this health check? Yes /No

Do you consent for us to share this health check information with your registered Dr? Yes/ No

Do you consent to share your contact details (for follow up results etc) with SCS Street team? Yes/No

\*\*\*Patient

Signature.....\*\*\*

### 2. Patient Details

Demographics	
Name	
DOB	
Age	
Ethnicity	
CHI:	
Best way to contact you? Phone Number? Hostel/ Worker?	
Accommodation?	
Where are you living?	
Rough sleeping? / Ever Rough Slept?	
Have you made a homeless application? / In past 6 months?	
How long have you been homeless?	
General Health Information	
Last Registered GP? (& Address)	
Last visit to GP	
What pharmacy do you use?	
Other health workers engaged with?	
Other services engaged with?	

When was your last visit to A&E?

What was the reason for your last A&E visit?



### 3. EQ5D5L

(See Appendix 1.1 for Additional EQ5D forms)

Under each heading, please tick the ONE box that best describes your health TODAY.

#### MOBILITY

I have no problems in walking about

☐

I have slight problems in walking about

☐

I have moderate problems in walking about

☐

I have severe problems in walking about

☐

I am unable to walk about

☐

#### SELF-CARE

I have no problems washing or dressing myself

☐

I have slight problems washing or dressing myself

☐

I have moderate problems washing or dressing myself

☐

I have severe problems washing or dressing myself

☐

I am unable to wash or dress myself

☐

#### USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities

☐

I have slight problems doing my usual activities

☐

I have moderate problems doing my usual activities

☐

I have severe problems doing my usual activities

☐

I am unable to do my usual activities

☐

#### PAIN / DISCOMFORT

I have no pain or discomfort

☐

I have slight pain or discomfort

☐

I have moderate pain or discomfort

☐

I have severe pain or discomfort

☐

I have extreme pain or discomfort

☐

#### ANXIETY / DEPRESSION

I am not anxious or depressed

☐

I am slightly anxious or depressed

☐

I am moderately anxious or depressed

☐

I am severely anxious or depressed

☐

I am extremely anxious or depressed

☐

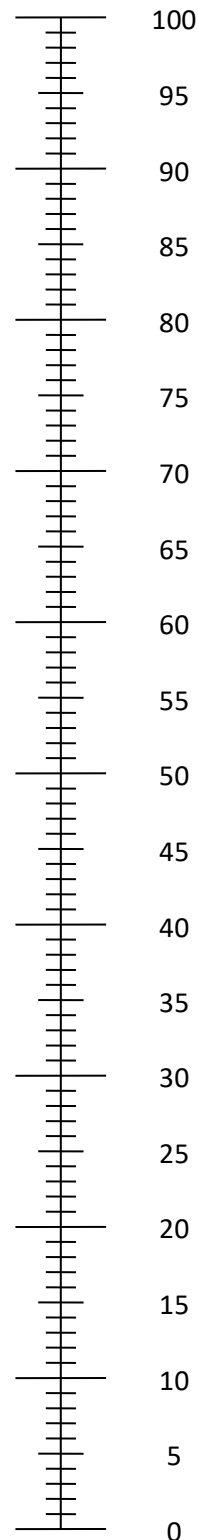
We would like to know how good or bad your health is TODAY

100 means the best health you can imagine.

0 means the worst health you can imagine

Mark an X on the scale to indicate how your health is TODAY

Now, please write the number you marked on the scale in the box below.



Your Health Number Today (Date:.....is:.....) (Date:.....is:.....)

How do you think you could improve this number? \_\_\_\_\_

What would you like help with today? \_\_\_\_\_

**4. CARDIOVASCULAR** - No Cardiovascular Problems ☐ / Section not filled in -TR ☐ NCR ☐ ND

<p>1) Patient History:</p> <p>_____</p> <p>Angina</p> <p>Heart attack</p> <p>Ankle swelling</p> <p>CABG</p> <p>PCI</p> <p>PVD</p> <p>Stroke/ TIA Mini</p>	<p>2) Family History:</p> <p>Mother or father /brother or sister ever suffered:</p> <p>_____</p> <p>MI</p> <p>Angina</p> <p>TIA</p> <p>Stroke</p> <p>@ under 60yrs?</p>
<p>3) Physical investigations</p> <p>_____</p> <p>BP</p> <p>_____</p> <p>Pulse and O<sub>2</sub> sat</p> <p>_____</p> <p>Pulse Rhythm _____ Reg / Irreg</p> <p>_____</p> <p>Single lead ECG (not for people with AF/pacemaker): Normal....Abnormal/unclassified...AF... (palpitations, dizziness, breathlessness, fatigue, syncope)</p>	<p>4) Risk Score:</p> <p>ASSIGN Score</p> <p>if no CVD: <a href="http://assign-score.com/estimate-the-risk/">http://assign-score.com/estimate-the-risk/</a></p> <p>(use population cholesterol score) use QQ1 1QQ postcode</p> <p>.....</p>
<p>Summary &amp; Follow Up:</p> <p>Refer for 12 lead ECG if AF/Abnormal/Unclassified</p>	

**5. RESPIRATORY** - No Respiratory Problems ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

<p>1) Patient History</p> <p>_____</p> <p>COPD</p> <p>Chronic Bronchitis</p> <p>Emphysema</p> <p>Asthma</p> <p>If you have asthma or COPD do you think it is well controlled?</p> <p>_____</p> <p>TB</p> <p>Contacts with TB?</p>	<p>2) Family History – any asthma/COPD?</p> <p><b>Fever or Weight loss or Night sweats?</b></p> <p>ask for sputum sample: spit into pot, request ‘culture and stain and mycobacterium culture’</p> <p><b>CXR if resp and wt loss, haemoptysis or fevers</b></p>
<p>3) Current Symptoms</p> <p>_____</p> <p>Do you have a cough?</p> <p>Do you bring up phlegm?</p> <p>Is your breathing ever wheezy (noisy)?</p> <p>Do you cough at night?</p> <p>_____</p> <p>Do you get night sweats/fevers?</p> <p>Have you coughed up blood?</p>	<p>4) Smoking Status</p> <p>Number cigarettes/day:</p> <p>Rollups/day (half ounce = 15g tobacco = 20cigarettes)</p> <p>Age started.....</p> <p>Age stopped.....</p> <p>Have you tried to stop?</p> <p>Do you know where to access stop smoking services?</p> <p>_____</p>

<u>Do you get breathless?</u> <u>If so, when and what were you doing?</u> <u>How breathless do you get?</u> MRC1(no restrictions) 2 3 4 5 (SOB any movement)	Temp > 38, RR > 25breaths per min, HR > 110 - → arbitrary cut off for severe exacerbation/sepsis  PEFR....                      ..... % predicted (< 30-50% = severe/acute) Chest exam... percussion...auscultation... (wheeze? Bilateral crackles?                      ) vocal resonance
Summary and follow up:	

**6. EATING AND DRINKING** - No Nutritional Problems ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

1)Patient History	
<u>Do you eat three meals a day?</u>	<u>Hot meals?</u>
<u>Variety of food?</u>	<u>Healthy food?</u>
<u>Where do you get most of your food from?</u>	<u>Do you know where to get free hot meals</u>
<u>Seen a dietician before?</u>	
2)Physical Assessments	
<u>Weight:</u>	
<u>Height:</u>	
BMI : <b>BMI:</b> <18.5 underweight . Normal 18.5-24.9. Overweight 25–29.9. Obese ≥ 30	
<u>New weight loss/weight gain?</u>	
<u>Previous Weight (date)</u>	
MUST score: .....if ≥ 2: Give ‘Eating to feel better leaflet’; start ensure; refer to dietician; monitor in 1 month*	
Score: (BMI <18.5 = 2; 18.5 – 20 = 1) + (Unplanned loss 3-6month <5% = 0; 5-10% = 1; >10% = 2) +(Acute ill + °intake likely > 5 days = 2).	
Random blood glucose:	
Any diabetic symptoms e.g. thirst/frequency urination etc?	
Fasting BG:	
*(6-7 poss T2DM so check HbA1c. ≥ 7 T2DM diagnostic, check HbA1c)*	
Summary & Follow Up:	

**7. FEET** - No Problems ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

<u>Do you suffer any problems with your feet?</u>				
Ulcers	Blisters	Ingrown toenails	Heel pain	Neuropathy
Corns/calluses/verrucae		Athletes foot	Fungal nails	Other
Monofilament screen				
Eyes closed, tell us if there is feeling and if so where * < 8 phone David H				
Right foot...../ 5 plus heel		Left foot...../5 plus heel		
Summary and Follow up:				

**8. MENTAL HEALTH - No Mental Health Problems** ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

Do you suffer from any mental health problem?  
 Have you ever had a mental health illness in the past?  
 Any name or diagnosis given for it? Do you have a mental health worker / nurse currently?

Depression Screen. *For further mental health measures (Depression and Anxiety), see Appendix 2.1 (PHO-4)*

\*Lost interest in things you used to enjoy? \*Persistent low mood?  
 Any problems/feelings of :  
 Sleep (increase or decrease), Activity (increase or decrease),  
 Guilt/ Worthlessness, Appetite changes, Fatigue, Concentration poor?  
 For how long?  
 Suicide attempts? Self harm? How are you feeling in yourself today?  
 \* core symptoms\* depression suspected if around 5 of these symptoms present including core

Psychosis Screen. *For further mental health measures (psychosis) see Appendix 2.2*

Appearance: Behaviour:  
 Speech: any disorder of thought form e.g. flight/ word salad/ or stream e.g. pressured/block  
 Mood: persistent change/ fluctuating change/ Incongruity  
 Thoughts: disorders of content/ disorders of possession  
 Perceptions: hallucinations/ illusions/ depersonalization/ derealisation/ Heightened sensitivity  
 Summary and Follow up:

**9. SUBSTANCE MISUSE- No Substance Misuse Problems** ☐ /

**Intoxicated?:** Drowsiness...slurred speech...respiratory depression-  
**Overdose:** UNCONSCIOUS; SLOW/SHALLOW IRREGULAR RASPING/ BREATH/ PINPOINT PUPILS/  
 EXTREME SLEEPINESS/ CAN'T TALK/ BLUE PURPLE  
 -Third dying from OD have respiratory problem...GABA /alcohol /cocaine /crack /benzos...no naloxone  
 -Botulism: non IV injecting...inflammation at site...blurred vision cannae swallow/speak...paralysis  
 -Naloxone? Lasts 20mins only. Inject through clothing outer thigh, patient can be aggressive when comes around.  
 -Need to call 999 even if need / want to leave.

Know where to access safe needles Want some from us today?  
 Had OD training? Do you have naloxone? Want some from us today?  
 Any previous overdoses yourself/others? Aware of the danger times to overdose and mixing drugs

Any current drug use?	Heroin	Valium	Cocaine	Spice	Other
How often?	How much?		Route:		
injecting:.....arms.....legs.....groin....other.....	Smoking	Snorting	Tablets		

Since when?	Past week typical?	If so how much you had in past week?	Frequency of use:
Check any past/current injection site problems:...Abscesses.....Ulcers.....Infection at site....DVT....muscle pop.....cellulitis.....blown vein....swelling.....nerve damage.....citric burn.....Other.....Location:			
Currently receiving methadone /buprenorphine?		Last dose: < 48hrs ago > 72hrs ago	
Been on methadone/subox/buprenorphine treatment before? 16mg buprenorph ~ 50ml meth			
Who is /was your worker?		Pharmacy:	
Check that not on Rx elsewhere:			
<b>In opiate withdrawal?</b>			
-Racing Pulse (>80)	.....		
-Dilated Pupils	wide.....normal.....normal		
-Palms	wet.....moist.....normal		
-Skin	goosed.....cold.....normal		
-Yawning	.....no		
-Runny Nose	running.....sniffing.....normal	Runny eyes- *consider non sedating antihistamine*	
-Agitation	can't sit.....agitated.....normal		
-GI	vomiting.....nausea.....normal	diarrhoea – *consider loperamide*	
-Bone joint aches muscle pain stretchy- *consider paracetamol*			
Urine: COC....AMP....MTD...MOP (opiates)...BZO....BUP....		DBS:.....Big purple bottle for Hep C/B...HIV...Syphilis	
If not on script why not? Don't want to.....Barred.....Too dangerous to access CAT/HAT building.....missed appointments and removed from list .....Can't comply with structured appointments: Too unwell to make way to HAT/CAT Relationship breakdown with worker.....Uncomfortable travelling to CAT/HAT due to health risks encountering different people.....uncomfortable waiting too long.....drop in suits better....			
Do you want to get into treatment for your heroin use?			
Do you want us to help you get onto treatment?			
Phone HAT duty senior: [contact details removed for confidentiality] time: and pass on all above information verbally and / or on referral form...			
Would it work better for you if we were able to start you on methadone for 3-7 days then go to HAT/CAT?			
Any current /pending justice issues?		Any children or dependents?	
Date and time of response from CAT/HAT:			
Response:		Follow up:	

**10. ALCOHOL** No Problems with Alcohol ☐ / Section not filled in -TR ☐ NCR ☐ ND ☐

Do you drink alcohol?	How much a day?	Binge?
Age started	Looking to stop / reduce?	Do you want referred for help?
Stopped before?	Any previous help from addictions services?	Reason for relapse?

Any current/pending justice issues?

Any children/dependents?

**CAGE QUESTIONS \*2 or more indicate potential issues for further investigation\***

Have you ever felt you needed to Cut down on your drinking? Y N
Have people Annoyed you by criticizing your drinking? Y N
Have you ever felt Guilty about drinking? Y N
Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover? Y N

**Current Physical Symptoms**

Sweating? Y N	Agitation? Y N
Hallucinations? Y N	Tremor? Y N
Disorientated? Y N	Seizures? Y N

**Hx of alcohol use with diarrhoea, vomiting, physical illness, weight loss, poor diet/malnourished? suggests at risk of Wernicke's encephalopathy/Korsakoff's psychosis:** refer to GP for Pabrinex IM High potency; Rx thiamine at least

**11. BBVs** No Problems with BBVs ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

Ever been tested for BBVs? Offer BBV test if > 3 months since last check and ongoing risk
Hep B Status
Hep C Status
HIV Status
Risky behaviors? e.g. needle sharing, unprotected sex (need 3-6 months after exposure to detect)
Would you like tested now?
How can we reach you with your result?
Would you know where to get help if you were infected?
Summary & Follow up:
Hep A vaccination indicated? Hep B vaccination indicated?

**12. SEXUAL HEALTH** - No Problems ☐ / Section not filled in TR ☐ NCR ☐ ND ☐

Have you ever had any Sexually Transmitted Infection or Disease? Y N	
Are you at risk of obtaining a STD? Y N	Lat STD test?.....
Have you any unusual changes down below in your genital area e.g. warts, discharge, bleeding? Y N	
Summary & Follow up:	
<b>Female health</b>	
Are you pregnant or chance could be pregnant?	Last smear test done (3 yearly)?
Do you use contraception? /If so, what do you use?	Hysterectomy?
If not, would you consider contraception?	
Summary & Follow up: Sandyford Drop in 8.30am-8pm 2 Sandyford Place Sauchiehall St. 211 8130	

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**13. WOUNDS** No Problems ☐ / Section not filled in TR ☐ NCR ☐ ND ☐

Any wounds?	Need dressed?
Last time dressed?	Know where to access dressing & cleaning?
Dermatology/wounds – ask patient’s permission and email picture with CHI number and wee bit of background to <a href="mailto:Angela.Drummond@ggc.scot.nhs.uk">Angela.Drummond@ggc.scot.nhs.uk</a> and <a href="mailto:Grant.Wylie@ggc.scot.nhs.uk">Grant.Wylie@ggc.scot.nhs.uk</a>	
Last tetanus?	
Summary/ further actions	

**14. FRACTURES** No Problems ☐ / Section not filled in TR ☐ NCR ☐ ND ☐

Broken bones?	Ever had > 3 months of $\geq 5$ mg prednisolone?
Any family members fractured a hip?	If yes to at least 2 of these, input details on FRAX website
10 year risk of fracture:	10 year risk of hip fracture:
Summary/ further actions (see NOGG link in FRAX tool)	

**15. OTHER** serious illnesses, operations, accidents...No ☐ / Section not filled in - TR ☐ NCR ☐ ND ☐

Head Injury? Details	Teeth problems?
Seizures ? Reason?	Any pain?
Eyesight trouble?	Skin conditions?
Hearing loss?	Allergies
Grip Strength:	

**16. MEDICINE REVIEW** - No Problems ☐ / Section not filled in TR ☐ NCR ☐ ND ☐

Medication	Last taken?	Pharmacy?	Prescribed by?	Any changes indicated?
Summary and plan:				

**VENEPUNCTURE- Blood:** if indicated; if we can follow up; and if patient agreed to act on results. Arm straight btw

**Drill for taking blood samples direct to lab**

**Big purple – Hep C, B, HIV, Syphilis.** Take sample to Virology, Level 5 Lister Building, Alexandra Parade, Glasgow Royal. Ask for form to complete the transfer. Check portal for results after a few days (search surname+forename+DoB if no CHI) or email request for results to [west.ssv@nhs.net](mailto:west.ssv@nhs.net)

**Yellow (Ochre) - Ca, LFTs, Alb, CRP, H Pylori, Total and LDL Chol, U&Es, + Mg if on PPI and / or Bev, 25 hydroxy Vit D GGTs B12 Bone.** Take sample to Biochem dept, Ground floor beside ambulance bay, Glasgow Royal, off Alexandra parade. Complete a Biochemistry and Haematology request form for each patient (one form covers Ochre, wee purple and grey bottle). Check results on portal in a few days.

**Wee purple - FBC differential, HbA1c** Complete a Biochemistry and Haematology request form for each patient (one form covers Ochre, wee purple and grey bottle). Check results on portal in a few days.

**Grey - Glucose** Complete a Biochemistry and Haematology request form for each patient (one form covers Ochre,

**Derived scores:**

- AF: CHA<sub>2</sub>DS<sub>2</sub>-VASc Score
- ASSIGN if no CVD: (<http://assign-score.com/estimate-the-risk/>)

**Fibrosis -4 score** estimates liver scarring in HCV and HBV to assess need for fibroscan or biopsy. Normal: AST < 40; Plats 150-350; ALT < 35 **Fib 4 score** =  $\frac{[Age\ (yrs)] \times [AST\ (u/l)]}{[Plats\ (10^9/l)] \times [\sqrt{ALT\ (u/l)}]}$

Low fibrosis scores may be ok for med management. Severe fibrosis/cirrhosis scores (> 3.25) suggest advanced fibrosis, liver disease, hepatocellular carcinoma and may need liver biopsy for confirmation of cirrhosis unless there are signs of progression to end stage liver disease. NB Alcohol excess increases AST and decreases Platelets so Fib 4 falsely raised.

- For both male and female >50 Bowel Screening kit offer .....
- Fitba: ...offer training Mondays and Thursdays 3-5, Petershill Park, 30 Adamswell Street, G21 4DD. [Contact removed for confidentiality]

**Referral ground rules**

Always Check GP records + clinical portal or TRAK + phone pharmacy for confirmations

Prescribing:

Check existing Rx status (from GP records, Portal, Community Pharmacy). Take Rx to pharmacy. Agree follow up.

Consider daily/weekly dispensing

**Useful Contacts**

[Names and details removed for confidentiality]



**Consultation 1:**

Problems:

Assessment:

Plan/ Action:

Follow up:

**Consultation 2**

Date:

Location:

Completed by:

How was patient brought to your attention?

Best way to contact you?

Phone Number?

Hostel/ Worker?

Where are you living?

Rough sleeping?

Last visit to GP

Most recent Rx

What pharmacy do you use:

Other health workers engaged:

EQ5D5L:

Problems:

Assessment:

Plan/ Action:

Follow up:

### Consultation 3

Date:

Location:

Completed by:

How was patient brought to your attention?

Best way to contact you?

Phone Number?

Hostel/ Worker?

Where are you living?

Rough sleeping?

Last visit to GP

Most recent Rx

What pharmacy do you use:

Other health workers engaged:

EQ5D5L:

Problems:

Assessment:

Plan/ Action:

Follow up:

#### Consultation 4

Date:

Location:

Completed by:

How was patient brought to your attention?

Best way to contact you?

Phone Number?

Hostel/ Worker?

Where are you living?

Rough sleeping?

Last visit to GP

Most recent Rx

What pharmacy do you use:

Other health workers engaged:

EQ5D5L:

Problems:

Assessment:

Plan/ Action:

Follow up:

APPENDIX 1.1: EQ5D5L

Visit number:  
.....Date.....Location.....

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

I have no problems in walking about

I have slight problems in walking about

I have moderate problems in walking about

I have severe problems in walking about

I am unable to walk about

SELF-CARE

I have no problems washing or dressing myself

I have slight problems washing or dressing myself

I have moderate problems washing or dressing myself

I have severe problems washing or dressing myself

I am unable to wash or dress myself

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities

I have slight problems doing my usual activities

I have moderate problems doing my usual activities

I have severe problems doing my usual activities

I am unable to do my usual activities

PAIN / DISCOMFORT

I have no pain or discomfort

I have slight pain or discomfort

I have moderate pain or discomfort

I have severe pain or discomfort

I have extreme pain or discomfort

ANXIETY / DEPRESSION

I am not anxious or depressed

I am slightly anxious or depressed

I am moderately anxious or depressed

I am severely anxious or depressed

I am extremely anxious or depressed

100

95

90

85

80

75

70

65

60

55

50

45

40

35

30

25

20

15

10

5

0

We would like to know how good or bad your health is TODAY.

100 means the best health you can imagine.

0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is TODAY.

Now, please write the number you marked on the scale in the box below.

Your Health Number TODAY = \_\_\_\_\_

43

How do you think we could improve this number? \_\_\_\_\_

## APPENDIX 2.1. Mental Health measure (Depression and Anxiety)= PHQ-4

### PHQ-4

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use “✓” to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

#### Scoring

PHQ-4 total score ranges from 0 to 12, with categories of psychological distress being:

- None 0-2
- Mild 3-5
- Moderate 6-8
- Severe 9-12

Anxiety subscale = sum of items 1 and 2 (score range, 0 to 6)

Depression subscale = sum of items 3 and 4 (score range, 0 to 6)

On each subscale, a score of 3 or greater is considered positive for screening purposes

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The PHQ scales were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, and Kurt Kroenke and colleagues. The PHQ scales are free to use. For research information, contact Dr. Kroenke at [kkroenke@regenstrief.org](mailto:kkroenke@regenstrief.org)

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

## APPENDIX 2.2. Mental Health measure (Psychosis)<sup>2</sup>

<b>PSYCHOSIS SCREEN (Yale Psychosis screen)</b> Indicate below the statement that best represents your level of agreement with the prior statement.	<b>Definitely Disagree (0)</b>	<b>Somewhat Disagree (1)</b>	<b>Slightly Disagree (2)</b>	<b>Not Sure (3)</b>	<b>Slightly Agree (4)</b>	<b>Somewhat Agree (5)</b>	<b>Definitely Agree (6)</b>
1. I think that I have felt that there are odd or unusual things going on that I can't explain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I think that I might be able to predict the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I may have felt that there could possibly be something interrupting or controlling my thoughts, feelings, or actions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have had the experience of doing something differently because of my superstitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I think that I may get confused at times whether something I experience or perceive may be real or may be just part of my imagination or dreams.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have thought that it might be possible that other people can read my mind, or that I can read other's minds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I wonder if people may be planning to hurt me or even may be about to hurt me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>2</sup> Prevention through Risk Identification, Management, and Education (PRIME) group at Yale University (the PRIME screen). <http://www.schizophrenia.com/sztest/primetest.pdf>



8. I believe that I have special natural or supernatural gifts beyond my talents and natural strengths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I think I might feel like my mind is “playing tricks” on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have had the experience of hearing faint or clear sounds of people or a person mumbling or talking when there is no one near me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I think that I may hear my own thoughts being said out loud.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I have been concerned that I might be “going crazy”.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## About I-SPHERE

The Institute of Social Policy, Housing and Equalities Research (I-SPHERE) at Heriot-Watt University is a leading UK research centre in the fields of housing, poverty and social policy with a strong international reputation. I-SPHERE staff specialise in research on homelessness, destitution, complex needs and other forms of severe disadvantage.

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